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Issue Date: 22 April 2005

CASE NO.: 2002-LHC-1609

OWCP NO.: 02-101625

IN THE MATTER OF:

GILBERT W. HAWKINS (DEC)
Claimant

v.

HARBERT INTERNATIONAL, INC.,
Employer

and

INSURANCE COMPANY OF NORTH AMERICA,
Carrier

APPEARANCES:

John D. McElroy, Esq.
On behalf of Claimant

Patrick E. O'Keefe, Esq.
Scott Hymel, Esq.
On behalf of Employer

Before: Clement J. Kennington
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This is a claim for benefits under the Longshore and Harbor Workers' Compensation Act (the Act), 33 U.S.C. § 901, *et seq.*, brought by Jamey L.

Everett, (Claimant) the stepson of Gilbert Hawkins (Decedent), against Harbert International, Inc. (Employer) and Insurance Company of North America. (Carrier). The issue presented could not be resolved administratively, and the case was referred for a formal hearing. The hearing was held on November 20, 2002 in Lake Charles, Louisiana.

At the hearing all parties were afforded the opportunity to adduce testimony, offer documentary evidence, and submit post-hearing briefs in support of their positions. Claimant testified and introduced twenty-six exhibits, which were admitted including: filings with the U.S. Department of Labor; prior Decisions and Orders in this matter dated May 31, 1994, May 21, 1998, and December 21, 1999; a notice of decision from the Social Security Administration; Social Security earnings records; the medical records and deposition of Dr. Kashinath Yadalam; medical records from Lake Charles Mental Health Clinic, Children's Clinic of Southwest Louisiana, Moss Regional Hospital, Lake Charles Memorial Hospital, St. Patrick Hospital, and DeRidder Clinic; medical records from Drs. Edgar McCanless, Clyde Smoot, Robert Korber, Shakeel Sandozi, and King White; Winn Correctional Center records; Employment termination records; a power of attorney dated July 24, 1994; the vocational report and C.V. of William J. Kramberg; and the declaration of insurance records.[1]

Employer filed eight exhibits, which were admitted, including: filings with the U.S. Department of Labor; a memorandum of the informal conference dated August 7, 2001; medical records from Lake Charles Mental Health Clinic; records from Winn Correctional Center; a psycho-educational evaluation by Alice P. Williams, LLC, dated September 19, 1988; an evaluation by Dr. George Middleton; a report by Mitchell Stephens dated January 28, 1998; and the deposition and psychological evaluation by Lawrence S. Dilks dated September 10, 1998.[2]

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[1] References to the transcript and exhibits are as follows: trial transcript- Tr.___; Claimant's Exhibits- CX-____, p.___ of ___; Employer's Exhibits - EX-____, p.__ of __; Administrative Law Judge Exhibits- ALJX-____, p.__ of ____.

[2] This decision has been delayed for almost two years due to the Social Security Administration's refusal to allow Dr. Dilks, who serves as a consultative psychological expert, to testify in this proceeding in response to a subpoena issued by Employer. The Social Security Administration relented only after the U.S. District Court, Western District of Louisiana, Lake Charles Division ordered Dr. Dilks to testify and a compromise was reached while the matter was on appeal before the U.S. Fifth Circuit Court of Appeals.

The parties argued orally and filed post-hearing briefs on April 8, 2005. Based upon the stipulations of the parties, the evidence introduced, my observation of the witness demeanor and the arguments presented, I make the following Findings of Fact, Conclusions of Law, and Order.

I. STIPULATIONS

At the commencement of the hearing the parties stipulated and I find:

1. Claimant Everett was born July 31, 1973;

2. Claimant Everett is the stepson of Gilbert Hawkins;

3. Gilbert Hawkins died on December 21, 1989;

4. Claimant Everett Hawkins was wholly dependent on Gilbert Hawkins when he died on December 21, 1989;

5. Gilbert Hawkins's average weekly wage was $804.05, and any death benefits owing are subject to annual costs of living adjustments pursuant to Section 10(f) of the Act;

6. Claimant Everett turned eighteen years of age on July 31, 1991;

7. Employer/Carrier does not contest Claimant's entitlement to benefits as a "child" under 33 U.S.C. § 902(14) until he reached his eighteenth birthday;

8. Mary Hawkins, Claimant's mother continued to receive benefits under Section 9 of the Act; and

9. An informal conference was held on August 7, 2001.

II. ISSUES

The following unresolved issues were presented by the parties:

1. Whether Claimant has been incapable of self-support since his 18th birthday (July 31, 1991) by reason of physical or mental instability, and thus, entitled to continuing death benefits under the Act.

2. Interest and attorney's fees.

III. STATEMENT OF THE CASE

A. Chronology:

On May 31, 1994, Administrative Law Judge Edward Therune Miller issued a Decision and Order in this case adjudicating the rights of Gilbert Hawkins's widow, Mary J. Hawkins. *Hawkins v. Harbert/Jones*, 91-LHC-1649 (May 31, 1994); (CX-3). Judge Miller determined, *inter alia*, that the Office of Administrative Jaw Judges had jurisdiction over the claim for compensation because Gilbert Hawkins was employed under a contract of the United States to construct a public works project in Cairo, Egypt. (CX-3, p. 2). Gilbert Hawkins died on December 21, 1989, as a result of a work related heart attack. *Id*. At the time of his death, Gilbert Hawkins was the sole source of support for his spouse and her minor children, Claimant Louis Everett, born July 31, 1973, and Robert King Everett, born October 25, 1975. *Id*. at 4. Judge Miller determined that death benefits were payable under the Act. *Id*. at 13, 15.

On May 21, 1998, the parties reappeared before this Court litigating the rights of Robert King Everett as a "child" pursuant to Section 2(14) of the Act until his high school graduation, and contesting whether Robert King Everett was a "student" under Section 2(18) of the Act following his eighteenth birthday. *Hawkins v. Harbert International, Inc.*, 91-LHC-1649 (May 21, 1998) (ALJ); (CX-4, p. 4). In that proceeding, I determined that Robert King Everett was both "child" and a "student" as defined by the Act, and that decision was affirmed by the Board. (CX-4, p. 10); *Hawkins v. Harbert International, Inc.*, BRB Nos. 99-0396, 99-0396(A) (December 21, 1998); (CX-4, p. 10).

On September 24, 1999, Administrative Law Judge Charles R. Lindsay, with the United States Social Security Administration rendered a fully favorable decision for Claimant. (CX-6, p. 1). Claimant had filed an application for child's

insurance benefits under Section 202 (d) of the Social Security Act as amended on May 24, 1995, alleging that he was disabled due to manic depression, kleptomania, dyslexia, and hyperactivity. *Id*. at 6. Judge Lindsay determined that Claimant Everett had a "severe" bi-polar disorder which met the Social Security's listing requirement under Section 12.04 A3, B1, 2, and 4 of Appendix 1, Subpart P, Regulations No. 4. Judge Lindsay's decision was based in large part upon a report of consultative psychological expert. Dr. Kip M. Patterson who concluded that Claimant allegedly had marked restrictions in daily living, social functioning with repeated episodes of deterioration or decomposition in work or work like settings. Neither Dr. Patterson's report nor the basis of his conclusions was made a part of this record. *Id*. at 12. Claimant now seeks adult dependency benefits under the Longshore Act.

B. Claimant's Testimony

Claimant, a 31 year old male, alleged dependency upon his mother due to a combination of physical and mental impairments. He testified that he had a heart condition such that he experienced pain with the onset of stress. (Tr. 15-16). Stressors included worrying about what would happen tomorrow, and worrying who would take care of him if his mother died. Over the past few years, he noticed an increase in chest pains and he twice sought medical treatment. (Tr. 16). In June, or July, 2002, Claimant related that he had an angioplasty performed by Dr. White, and otherwise his condition was treated with nitroglycerin pills, which he took once or twice a week. (Tr. 17).

Claimant testified that he had low back problems due to SI joint dysfunction, which cause him constant lower back and right hip pain that started in the 1990s. (Tr. 18-19). Claimant traced the etiology of his back pain to a fall down a set of concrete stairs when he was seven or eight years of age. (Tr. 19-20). For treatment, he took medication and received injections every six weeks. (Tr. 20). With his lower back pain, Claimant testified that he was afraid to undertake any task such as prolonged walking or any lifting over ten pounds. (Tr. 21-22). Claimant stated that he had difficulty climbing stairs, he could not sit comfortably, and he had difficulty riding in a car over thirty minutes. (Tr. 22-23).

Claimant testified that he was shot in the neck and twice in the leg by his brother on June 22, 1999. (Tr. 23-26). Claimant related that he was still being treated for his wounds, he had to be careful to keep his skin grafts moisturized, and he stated that he was still scheduled for two plastic surgeries, two sets of skin

grafts and a scar revision to keep the wound from opening. (Tr. 26). As a result of his treatment, he could not stay in the sun and he could not become too sweaty. (Tr. 26). The after effects of the gunshot wound caused him to ache, he had the "shakes" because a bullet fragment nicked his spinal cord, and he had limited movement in his left arm. (Tr. 28). He also lost all or part of his left lung. (Tr. 47).

Claimant testified that his metal problems began to manifest in elementary school where he learned that he was hyperactive. (Tr. 29). He was on medication, the other students made fun of him, and he was forced to sit in the resource classroom because none of the teachers wanted to deal with him. (Tr. 30). Claimant also related that he was dyslexic and could not read like the other students. (Tr. 33). Before he had reached the age of seven, his mother hospitalized him for mental problems after he burned a house down. (Tr. 29). After moving from Shreveport, Louisiana, where he was treated by Dr. Levy, Claimant moved to Lake Charles, Louisiana, where he was treated by his pediatrician, Dr. McCanless, who continued his treatment for hyperactivity. (Tr. 32). Prior to turning eighteen Claimant testified that he was hospitalized for depression and suicide. (Tr. 37). Particularly stressful was when his father went to work overseas, and he attempted a suicide in 1985 by overdosing on hyperactivity medication. (Tr. 37). In 1988, Claimant related that he was diagnosed with a bi-polar disorder by Dr. Margaret Williams who prescribed Lithium. (Tr. 38-39). Currently, Claimant testified that he treats with psychiatrist Dr. Yadalam about every three months. (Tr. 40). He related that Dr. Yadalam's restrictions were such that he could not shop alone, go off by himself, and he should always take his medications. (Tr. 40-41).

Claimant described the symptoms of his bi-polar disorder as generalized irritability and a lack of tolerance such that anything out of the ordinary is disturbing to him. (Tr. 41). Sometimes his medications made him feel hallucinatory. (Tr. 41). He described his depression as "horrible." (Tr. 41). Lithium, which he takes four times a day for his bi-polar disorder, had the affect of making him sluggish and affected his weight because it had to be consumed with food. (Tr. 42-43). Claimant also takes Risperdal, Mellaril, Ambien, and Zanax for problems with hallucinations, hands shakes, sleep and anxiety. (Tr. 43, 44). Taking all of his medications caused him to drool. (Tr. 44-45). The total cost of his medications was approximately $600.00 to $1,000.00 per month. (Tr. 46). Medicare paid eighty percent of his doctor's bill and all of his prescription costs. (Tr. 49). Claimant testified that his only other treatment option was institutionalization, and that is what would happen to him if his mother was not there to care for him. (Tr. 45). The recommendation for institutionalization

occurred prior to his eighteenth birthday. (Tr. 46). Claimant testified that he was always a problem for his mother, but she obtained help from his aunt, Mrs. Lejune, who helped take care of him, provided a bedroom in her home, and who took him to church. (Tr. 46).

On July 31, 1991, Claimant Everett turned eighteen years of age. His school principal notified his mother that he needed special help in a private school and he was only wasting the schools time.[3] (Tr. 30). As of his eighteenth birthday, he was still living at home. (Tr. 36).

Claimant testified that he attempted to work in an effort to be normal. (Tr. 34). While he had a drivers license and a handicap sticker from the State, (due to trouble with walking), he testified that he was an unsafe driver with several accidents, thus, he tried to avoid driving. (Tr. 47). Nevertheless, he was able to drive by himself about once a week, and he had driven to church, his sister's house, and his aunt's house by himself. (Tr. 55). Because he was unable to work, Claimant testified that all of his current support comes from his mother, who received a Social Security check, death benefits, and a pension check. (Tr. 48-49). For his part, he received about nine hundred dollars a month in disability. (Tr. 49). Because Claimant testified that he was not competent to handle his own affairs, his mother held a general power of attorney on his behalf. (Tr. 49-50). All bills were paid by his mother, but she had him practice writing out checks so that he can do it in the event something happens to her. (Tr. 51). His mother told him to whom to write the checks and the amount. (Tr. 54). Without her help, Claimant testified that he would be unable to handle his financial affairs. (Tr. 52).

On one occasion he attempted to live apart from his mother. She rented the apartment, paid the utilities, periodically helped him out, and arranged for an older person to live with him. (Tr. 52). In total Claimant lived away from his mother about six months. (Tr. 60). During that time he would stay in daily contact by phone, his mother continued to manage his affairs, and she checked on him several

[3] Despite this trial testimony that he never finished high school, Angela Conner, a social worker, reported on July 5, 1995, that Claimant graduated high school and had attended Delta School of business for six months. (EX-3, p. 6). Gloria Kennedy, a social services counselor, who interviewed Claimant on September 27, 1993, reported that Claimant graduated from high school. *Id*. at 12. Likewise, an initial screening questionnaire dated April 7, 1997, listed Claimant as having a high school certificate. (CX-10, p. 8). Claimant testified that the people at the Mental Health Clinic never liked him and were always out to get him so that lied about his high school degree. (Tr. 80).

times a week. (Tr. 110-11). During this time, Claimant testified that he applied for work in twenty or thirty different places. (Tr. 61). Claimant's mother placed him in Delta School of Business, but after a short time he was asked not to come back because he was wasting their time. (Tr. 53). Subsequently, Claimant tried to attend a beauty school. (Tr. 59). Claimant was only able to stay in that school about two months because he had a lot of trouble with his hands shaking. (Tr. 59). Claimant testified that he could not type, and had no computer skills. (Tr. 60). He was able to find some work. He obtained a job at Pancho's, a restaurant, where he bussed tables for a few months. (Tr. 65). While he liked the job, he had difficulty getting along with his co-workers, and he found the work was stressful. (Tr. 65). Eventually, he was terminated because he could not keep up with the work, and because his supervisor did not think the work environment was compatible with his medications. (Tr. 65). His employment at Service Merchandise only lasted a few days because a man robbed the store with a shotgun, and after a brief shut-down, Claimant was terminated because he thought that the store no longer needed him. (Tr. 66). Claimant testified that he liked his job working at Goodwill, where he helped to train handicap people, but that he got on the nerves of his supervisor. (Tr. 67). That job lasted for less than two months. (Tr. 67). Claimant quit working at a job with Church's Chicken after one day because his job panning chicken made him sick to his stomach. (Tr. 68). At Diamond Shamrock, Claimant worked as a store clerk, but he never finished his training because he could not keep up. (Tr. 69). He also worked as a store clerk for E-Z Mart, but that job was also short lived because he could not keep up. (Tr. 69). Claimant's attempt to live on his own ended when he was arrested, and later convicted, for burglary.[4] (Tr. 61).

At the Winn correctional facility, Claimant testified that he was not in a psychiatric ward, but he was segregated. (Tr. 114). Eventually, Claimant moved to general population, with other disabled persons, he had a no-duty status, and out of the eighteen hundred people in the facility, Claimant was grouped with thirty disabled persons. (Tr. 114). While in prison, Claimant testified that he attended AA meetings, not because he ever had a problem with alcohol or drugs, but because he thought it would help him make parole. (Tr. 116). Regarding the form he filled out at the substance abuse meeting, Claimant testified that he did not remember filing out the form, his medications were not stabilized at that time, and

[4] Regarding his conviction for burglary, Claimant testified that he burglarized the apartment complex that he was living in. (Tr. 109). Claimant stole the bike of the person who lived in the apartment beneath him, the typewriter of another neighbor, and the personal belongings of another neighbor. (Tr. 112).

he may have been hallucinating while filling out the form. (Tr. 119-121). Claimant testified that he had consumed vodka, he had smoked marijuana, and he had taken weight loss pills, all substances for which he alleged abuse. (Tr. 119-121). Claimant denied using whiskey, and stated that in his lifetime he never smoked as much marijuana as he had indicated on his chart that he smoked in a week. (Tr. 123). Regarding his indication that he had attended AA or NA meetings before prison, Claimant testified that it was a lie, and he may have made that indication in an attempt to get into NA so that he could get out of his cell. (Tr. 122-23).

While at the State prison, Claimant testified that he was told when to wake up, go to bed, go to the bathroom, to take his medications, to report to work, and he was not afforded any free time. (Tr. 62-63). The prison work program first placed Claimant in the field, but he passed out, and an ambulance had to transport him for medical attention. (Tr. 63-64). Claimant was then placed in the kitchen to wipe off tables after the inmates ate, but he could not keep pace with the work. (Tr. 64). Claimant also had regular contacts with a psychologist and a psychiatrist. (Tr. 64).

After his discharge from prison, Claimant testified that his parole officer did not require him to work because he was discharged with a disabled status. (Tr. 70). Nevertheless, Claimant attempted to work at Dairy Queen as a cook, but that job only lasted a few days because he was too slow. (Tr. 71). Next, Claimant worked at Stanley Stores (Price Low), a grocery store, but his employment only lasted a few weeks because he could not lift heavy objects and he could not handle the tasks that he was given. (Tr. 71). Claimant's last job was at Amtex Enterprises, a job that he obtained through a family member, and which allowed him to lay down on a cot during the workday. (Tr. 72). At Amtex, Claimant testified that his job consisted of handing paperwork to a customer to fill out, and then taking the paperwork to a manager. (Tr. 128-29). Claimant's cash drawer was often short, but he did not know if it was his error or the error of a co-worker. (Tr. 130). Claimant testified that the person who hired him was stealing from the company and set him up as the fall person. (Tr. 72). After his co-worker was arrested, Claimant lost that job as well. (Tr. 72). At the formal hearing, Claimant testified that if there was a job that he could do that he would do it. (Tr. 73). Claimant disagreed with the statement of Gloria Kennedy based on a September 27, 1993 interview that he stole from almost every employer he ever worked for. (Tr. 134; EX-3, p. 12).

Claimant testified that he never worked in his mother's beauty shop. (Tr. 86). Claimant could remember cleaning up, sweeping hair, and taking out the

garbage a few times, but it was never a job and he did not receive any compensation. (Tr. 87). Claimant also testified that he was never allowed to stay at home by himself when his mother was working. (Tr. 89-90). Regarding a September 20, 1988 report by Alice Williams, that he could perform advanced housecleaning, household repair, maintenance, cooking, caring for cloths, making beds and sewing. (EX-5, p. 2). Claimant testified that he only started to cook a few years ago, he could make his bed, he could not manage his own money, but he was capable of performing chores. (Tr. 90-91). On a typical day he woke up around nine or ten o'clock, ate breakfast, watched television, and he did things around the house with his mother. (Tr. 56). He related that he was usually spilling, dropping, or breaking something. (Tr. 54). He was able to wash all of his cloths, but his mother did most of the ironing. (Tr. 56-57). The only other significant activity was taking a small dog out in the yard three or four times a day. (Tr. 57).

Claimant testified that he loved his mother, and that he never hired a person to kill her as detailed by Gloria Kennedy in a September 10, 1993 interview. (Tr. 149-50; EX-3, p. 9). Claimant never remembered saying any such thing to a counselor, and testified that it was a lie. (Tr. 150-51). Claimant also testified that he had a good relationship with his aunt Edith Lejune, and that he continues to stay at his aunt's house when his mother was unable to care for him. (Tr. 152).

C. Testimony of Mary Hawkins

Claimant's mother, Ms. Hawkins, testified that Claimant had only lived away from her once after the age of eighteen, and the reason he moved out was because they had a little trouble and she thought that he needed to try to be on his own. (Tr. 155-56). Ms. Hawkins testified that she found the apartment, paid all the bills, and would check to see how he was doing on a weekly basis. (Tr. 157). Ms. Hawkins related that Claimant was hyperactive at eighteen months of age, and he began to have mood swings at the age of seven. She traced Claimant's problems to a fall down a set of stairs after which his disposition totally changed. (Tr. 161-62). Claimant's hyperactivity was treated with Dexedrine until the age of thirteen, but his physician ended that prescription after Claimant allegedly attempted suicide by overdosing. (Tr. 164-65). Claimant often wrote suicide notes, and they began as soon as he could write. (Tr. 165).

Claimant did not like school and always received failing grades. (Tr. 166-67). After the first grade, Claimant was kept in the learning disabled classes. (Tr.

168). Four or five times a year, someone at school would assault Claimant, who had real problems getting along with other people after a short period of time.

At age sixteen, Ms. Hawkins related that Claimant attempted to kill himself a second time using a gun, and she admitted him to the mental ward at Lake Charles Hospital. (Tr. 169). Ms. Hawkins related that Dr. Williams diagnosed Claimant as bi-polar and started him on Lithium. (Tr. 170). Also prior to his eighteenth birthday, Ms. Hawkins testified that Claimant had problems with making up stories and lying. (Tr. 172). Claimant attended public school until the Ninth Grade, and when he was unable to go back into public school, Ms. Hawkins placed Claimant in Parkview, where he graduated some four months after he failed the Ninth Grade. (Tr. 172). The owner of Parkview, an unaccredited school at the time, gave Claimant enough training so that he could pass a test to get a diploma. (Tr. 173). In public school, Claimant never passed a grade, he was just socially promoted. (Tr. 174).

Over the years, Ms. Hawkins testified that she had filled out fifty to one-hundred job applications for Claimant. (Tr. 176). In the few jobs that Claimant did get, he rarely worked more than two weeks to two months. (Tr. 177). Ms. Hawkins testified that she provided everything for Claimant, including his clothing, medical care, bills, and she held a general power of attorney over his affairs. (Tr. 177-78). Ms. Hawkins was even the representative payee on his Social Security disability checks. (Tr. 178). The one time Claimant tried to manage his own finances Ms. Hawkins stated that she had to cover three thousand dollars in bad checks. (Tr. 182). Ms. Hawkins also related that Claimant could drive approximately fifty miles on his own he did not have a problem driving, and whenever he drove, she just hoped for the best. (Tr. 184).

Ms. Hawkins testified that during the time she operated a beauty salon, Claimant did not work for her. (Tr. 185). Ms. Hawking related that the statement by Alice Williams on September 20, 1988 that Claimant had a part time job working with her and earning money at her beauty salon was an incorrect statement. (Tr. 186; EX-5, p. 2). Ms. Hawkins also disputed the statement by Alice Williams that Claimant was home a lot at the age of fifteen, taking care of himself, because Ms. Hawkins related she took care to make sure that there was always someone supervising him. (Tr. 187-88).

When Ms. Hawkins sent Claimant to live in an apartment, she arranged for Claimant to live with a friend who was ten years older and she retained control over his money. (Tr. 189). Ms. Hawkins paid part of Claimant's expenses out of

his social security check, and the rest she covered out of her own pocket. (Tr. 190). While he lived in his apartment, Ms. Hawkins related that Claimant had a job at a Super Store, but he fell at work and the employer told him not to come back on the following day. (Tr. 191-92). Regarding his job at Service Merchandise, Ms. Hawkins related that he only worked there a few days and never stole any items form the store. (Tr. 193). She explained that Claimant would often make up stories to make himself "look big" and he often lied to his social workers. (Tr. 193). Ms. Hawkins was unaware that Claimant had ever told a counselor that he had hired someone to kill her, but she stated that Claimant would make such a statement in an effort to make himself look important. (Tr. 194). Ms. Hawkins also denied that she had a problem with Claimant's sexual preferences, and stated that any indication to the contrary from Claimant to a counselor was a fabrication on Claimant's part. (Tr. 218). Ms. Hawkins testified that she was not often present when Claimant was interviewed she thought that the counselors would be aware that Claimant was inherently untrustworthy because of his mental illness, and she did not see any harm in not correcting some of his falsehoods. (Tr. 218-19).

Regarding Claimant's job at Price Low, Ms. Hawkins related that Claimant was terminated because he could not meet the job requirements, and Claimant obtained a job at Dairy Queen through a friend. (Tr. 196-97). Ms. Hawkins went with Claimant to Dairy Queen and helped him fill out the application. (Tr. 197). Claimant obtained his job at Amex Finance through a friend of Ms. Hawkins' brother, who allowed Claimant to lay down at work. (Tr. 198). Ms. Hawkins opined that Claimant would only have been able to maintain that job if the friend of her brothers continued to work there with Claimant. (Tr. 200).

D. Testimony of Edith Lejune

Ms. Lejune, Claimant Everett's aunt, testified that Claimant started staying with around three years of age, and she would sometime take him for two weeks at a time. (Tr. 224-25). She kept in contact with Claimant two to four times per week and spoke with him on the telephone everyday. (Tr. 225). Ms. Lejune related that Claimant was hyperactive, told a few lies, and exaggerated. (Tr. 225). Claimant was capable of dressing himself, but needed help financially and he had problems interacting with other people. (Tr. 228).

E. Testimony of William Kramberg

Mr. Kramberg, a vocational rehabilitation counselor, testified that he performed a vocational assessment on Claimant. (Tr. 237). Mr. Kramberg interviewed Claimant on August 12, 2002, and based on Claimant's test results, Mr. Kramberg testified that Claimant had academic skills at an elementary school level. (Tr. 238-39). Based on his interview with Claimant, his testing and Claimant's medical records, Mr. Kramberg reported that Claimant was not competitively employable following his eighteenth birthday. (Tr. 239-40). Mr. Kramberg was not concerned that Claimant could not fill out an application for a job and eventually obtained one, rather, he was concerned that Claimant would be unable to keep that job. (Tr. 240). Claimant's lifelong mental health issues and lifelong difficulties in getting along with people drastically limited the amount and kind of work that he could perform. (Tr. 241).

Mr. Kramberg testified that he was familiar with statistical studies demonstrating that only three or four out of a hundred people with similar type problems could maintain employment. (Tr. 248). From his review of the record, Mr. Kramberg could not say that Claimant ever had the ability to work competitively within a vocational probability; rather the chance that Claimant could work competitively was a mere possibility. (Tr. 257-58). The fact that Dr. Yadalam encouraged Claimant to work did not mean that Claimant was capable of maintaining a job. (Tr. 275).

F. Exhibits

(1) Medical Records from the Children's Clinic of Southwest Louisiana

On July 9, 1980, Dr. Harold Levy reported that he first saw Claimant Everett on December 13, 1977, for treatment of enuresis, temper tantrums, not getting along with other children, and generally hyperactive behavior. (CX-11, p. 38). His impression was that Claimant had organic, minimal brain dysfunction syndrome, and Dr. Levy began a medication program to improve self-control. *Id*. Dr. Levy opined that Claimant may need special education intervention as well as changes in his medications as his needs develop. *Id*.

On November 18, 1982, the staff at the Children's Clinic noted that Claimant Everett was able to control himself as long as he received his medication. (CX-11, p. 28). His teachers reported that they were concerned about the stories he

told relating to imagined frightening things that have happened. *Id*. Claimant also lied excessively at school. *Id*.

(2) Medical Records of Dr. Edgar McCanless

On February 21, 1984, Dr. McCanless noted that Claimant Everett's teachers were begging for medication reporting that Ritalin was not working for Claimant's hyperactivity and Attention Deficit Disorder. (CX-14, p. 1).

(3) Medical Records from Lake Charles Memorial Hospital

On September 9, 1988, Claimant was admitted to Lake Charles Memorial Hospital with a diagnosis of attention deficit disorder and major depression. (CX-13, p. 1). Claimant's mother brought him to the hospital after he spoke of suicide, and teachers had telephoned her reporting that Claimant was "giggling" in class. *Id*. at 2. On September 19, 1988, Dr. George Middleton, a clinical neuropsychologist, noted that Claimant was oriented to time, place, and person, there was no evidence of delusions or hallucinations, and he cooperated well with testing. *Id*. at 13. A perceptual examination was normal, Claimant had reading, writing, and spelling difficulties, and a mild constructional dysphasia was observed. *Id*.

On September 20, 1988, Dr. Alice Williams, a treating child psychiatrist, ordered a psycho educational evaluation of Claimant. (CX-13, p. 8). In addition to depression, withdrawal, insomnia, and suicidal thoughts, the testing showed that Claimant was concerned about overeating, and he related that he would roll on the floor with temper tantrums. *Id*. Claimant's natural father was in prison for arson, and Claimant reported that he set a fire at the age of four that caused $10,000 in damage. *Id*. In testing, Claimant exhibited abilities in the low average range of intelligence. *Id*. at 9. In daily living skills, Claimant scored above average for his age group and, Ms. Williams noted abilities such as advance housecleaning, household repair, maintenance, cooking, caring for cloths, making beds, and sewing. *Id*. Claimant also worked part-time in his mother's beauty shop, saved, and managed his own money. *Id*. Claimant's social skills were low as he had a real difficulty in making friends, in social communication, and with interaction. *Id*. at 10. His coping skills were "extremely deficient" and he had trouble with being denied his way, taking constructive criticism, and he was unable to weigh the consequences of his actions before making decisions. *Id*. In a discharge note, dated October 23, 1988, Dr. Margaret Williams reported that Claimant had no evidence of a formal thought disorder and did not have any suicidal ideals. (CX-

13, p. 5).

(4) Medical Records from Lake Charles Mental Health Clinic

On September 10, 1993, Claimant sought mental health services because his mother threatened to have him committed to a State institution. (CX-10, p. 95). Health clinic personnel noted that Claimant had the anti-social violent episodes, was angry, vengeful, acted dangerously impulsively, and was a law breaker. *Id*. Claimant was homosexual, tried to commit suicide twice in 1988, and attempted to shoot himself. *Id*. Claimant also reported that he shot at people in cars and that he fought with his mother over money. *Id*. at 61. Claimant exhibited high risk behaviors as dishonesty, fear/phobia, depression, feeling nervous/tense, vengeful, and crying spells, social withdraw, and insomnia. *Id*. Gloria Kennedy, the social services counselor conducting the interview, traced the etiology of Claimant's symptoms to childhood and the immediate onset to a conflict with his mother who had declared bankruptcy, and failed relationships. *Id*. Claimant had even hired someone to kill his mother but he never followed through. *Id*. Ms. Kennedy thought that Claimant took pride in his appearance he had transportation, was willing to take medication, had learned skills, and could be self-supportive in the future. *Id*. at 63.

On September 23, 1993, Claimant reported problems with nervousness, oversleeping, headaches, and mood swings. (CX-10, p. 97). Claimant stated that he was always sick, had picked out a casket and wanted to be buried next to his grandmother. *Id*. Claimant reported that his deceased grandmother was always by him, he cried a lot, and he contemplated shooting himself. *Id*. On September 27, 1993, Ms. Kennedy reported that Claimant could not hold a job because his nerves could not handle it, and in fact he was fired from several jobs for stealing. *Id*. at 58. Claimant had trouble dealing with both his supervisors and co-workers. *Id*. Ms. Kennedy thought that Claimant had a borderline personality disorder and kleptomania with severe psychological stressors. *Id*. at 59. Claimant also related that he stole $9,000.00 in merchandise in 1992 from Service Merchandise, and he liked to enter "drag" contests, even placing as high as second place. *Id*. Other bad acts included continuing to use an ex-lover's credit card, setting fire to a relative's house by turning the stove burners up in an attempt to burn the food, breaking into several apartments and stealing cloths, and canceling an enemy's insurance coverage shortly before she had a bad accident. *Id*. Claimant also professed to possess paranormal abilities that enabled him to predict pregnancies and accidents. *Id*. at 59-60. In November, 1993, Lake Charles Mental Health Clinic discharged Claimant due to non-attendance, and later learned that Claimant was sentenced to

five years of prison in Lafayette, Louisiana. *Id*. at 96.

After serving nearly two years in prison, Claimant returned to seek treatment at Lake Charles Mental Health Clinic, and on May 23, 1995, he went through the walk-in clinic to obtain waiting list priority. (CX-10, p. 55). Angela M. Conner, a social worker, conducted an interview on June 7, 1995, where Claimant reported that he "needed some kind of peace," and he reported problems of insomnia, hair loss, shaking, nervousness, rage, mood swings, depression, hopelessness, overspending, poor impulse control, and a history of bi-polar disorder and risky behavior. *Id*. at 50. In the interview, Claimant exhibited hypersensitive, dramatic, manipulative, and dependent behavior. *Id*. at 51. His thought content included assaultive ideas, anti-social attitudes, suspiciousness, and ideas of hopelessness. *Id*. at 51. On June 20, 1995, Ms. Conner noted that Claimant was unemployed, that he wanted to complete beauty school, and that he normally got along okay with both his superiors and co-workers. *Id*. at 47.

On July 11, 1996, Claimant reported that he had persuasive problems of fear whenever he was left alone. (CX-10, p. 80). He stopped entering dark rooms, could not go outside alone without discomfort, and he was afraid to enter the bathroom when the shower curtain was closed. *Id*. He also described manic phases in which he threw violent tantrums, and was physically, as well as verbally, abusive. *Id*. On July 15, 1996, Claimant exhibited obsessive compulsive behavior. *Id*. at 79.

In an adult social history questionnaire dated August 13, 1996, Claimant reported bi-polar disorder, claustrophobia, risky behavior, mood swings, poor sleep, kleptomania, manipulative behavior, dependency, vengefulness, hallucinations, delusions, and anxiety. (CX-10, p. 19). Angel Courville, a registered nurse, noted that Claimant had identifiable precipitating factors to his mental disorders at less than four years of age. *Id*. at 21. Ms. Courville also noted two suicide attempts, one in 1988 when Claimant overdosed on drugs, and a second in 1993 when Claimant ran off the road two or three time because he had a bad home life. *Id*. Claimant also related that he suffered a head injury at eighteen months of age, he had to be resuscitated at birth, but was not put in a natal intensive care unit, and he weighed fifty pounds at the age of fourteen months. *Id*. at 23. His mother prepared his meals, he relied on family for transportation, and Claimant reported that he could not work because of his mental instability which caused him to have difficulty getting along with his supervisors and co-workers. *Id*. at 29-30. Ms. Courville commented that Claimant was "paranoid," he did not feel as if he could ever live by himself, he had panic attacks going out in the dark,

felt as if people were watching him, felt as if he might die at any time, did not trust anyone, was unable to drive, and he had obsessive compulsive tendencies. *Id*. at 32.

On March 3, 1997, Claimant reported that he did not see anything positive in his life or in his future, he continued to have auditory hallucinations, such as hearing a ringing telephone, and continued to have paranoid delusions, such as being afraid of people or believing that a person is behind the shower curtain. (CX-10, p. 73). On April 30, 1997, Claimant reported breaking every window in the house, and expressed a desire to run everybody off the road. *Id*. at 68. On May 30, 1997, Claimant expressed disinterest in vocational rehabilitation stating that "everyone knows I can't hold a job." *Id*. at 67.

In a discharge summary, dated January 28, 1998, Dr. Mitchell Stephens, a psychiatrist, noted that Claimant showed little progress despite numerous medication trials, and after he complained of the care he was receiving at Lake Charles Mental Health Clinic, Dr. Stephens referred Claimant to the Beauregard Mental Health Clinic which was closer to his home. (CX-10, p. 5-6). Dr. Stephens related that he informed Claimant that medications were not going to solve his problems and ultimately he would have to resolve his baseline anxiety and dysphoria. *Id*. at 7.

(5) Records from Winn Correctional Center

On January 6, 1994, Claimant reported to a correctional officer that his cell-mate had attacked him from behind and had forced sex. (CX-21, p. 11). In an April 25, 1994 mental health form, a social worker noted the Claimant complained of depression, audio/visual hallucinations, and confusion over his role in life. *Id*. at 118. Claimant exhibited homosexual activity, had a fetish for men's clothing, appeared anxious and paranoid. *Id*. He had a compulsion to steal. *Id*. The social worker recommended continued treatment with a psychologist, Dr. Van Buren. *Id*.

On February 9, 1994, Dr. Van Buren noted that Claimant Everett was a "very confused person." (CX-21, p. 121). Claimant denied auditory hallucinations but described visual hallucinations on several occasions. *Id*. Claimant was vengeful, and to prevent another overdose of medication, Dr. Van Buren recommended that Claimant's doctor change his medication. *Id*. On February 24, 1994, Dr. Van Buren reported that Claimant was a kleptomaniac, had symptoms of depression and paranoia and had overdosed on his medication again. *Id*. at 122. On March 2, 1994, Dr. Van Buren opined that Claimant's difficulties may be

resolved with intensive psychotherapy, which he would be unable to receive at the Winn Correctional facility, and he recommended that Claimant be transferred to a facility equipped to help him with his illness. *Id*. at 123. On April 27, 1994, Dr. Van Buren noted that Claimant was compulsively stealing food from the kitchen where he was employed, and Dr. Van Buren recommended that Claimant be given another duty. *Id*. at 127.

On May 11, 1994, Dr. Van Buren reported that Claimant was charged with aggravated disobedience for cursing at his supervisor in the cafeteria. (CX-21, p. 128). Claimant was unhappy that the prison physician changed his medications and Claimant described what appeared to be a loss of impulse control. *Id*. Claimant was irritable, argumentative, and refused to take his new medication. *Id*. On June 8, 1994, Claimant reported to Dr. Van Buren that he had not compulsively stolen anything in nearly three weeks. *Id*. at 131. Dr. Van Burned also noted that Claimant's illness was improved, in that he was able to think more logically, was rational, and much less depressed than previously. *Id*. By June 22, 1994, however, Claimant stopped taking his medication and became symptomatic again. *Id*. at 134.

On July 7, 1994, Dr. Aris Cox, a psychiatrist, determined that it was appropriate to discontinue all of Claimant Everett's medications considering the fact that Claimant had done without any since May of 1994 and seemed to be doing fine. (CX-21, p. 137). Dr. Cox recommended that Claimant only see him only on an as needed basis. *Id*. On July 20, 1994, Dr. Van Buren noted that Claimant was childishly dependent on his mother, believed everything she said, and believed his mother when she diagnosed him as manic depressive in need of medications. *Id*. at 138. On August 24, 1994, after nearly two months without medication, Dr. Van Buren noted that Claimant was very disturbed and he recommended another session with Dr. Cox, who later resumed Claimant's medication. *Id*. at 141.

(6) Social Security Administration Record of Earnings

An itemized statement of earnings from the Social Security Administration covering the period of 1992 to 2000 revealed that Claimant held the following jobs:

Year	Employer	Earnings
1992	National Tea Co.	$ 253.88
	H J Wilson Co., Inc.	$ 82.20

	Good Will Industries of South West Texas	$ 939.25
	Popeye's Famous Fried Chicken	$ 44.63
	Diamond Shamrock Refining	$ 648.13
1993	H J Wilson Co., Inc.	$ 18.59
	E-Z Mart Stores, Inc.	$ 256.50
	PMB Enterprises West, Inc.	$ 1,181.72
1996	Stanley Stores, Inc.	$ 1,870.94
1999	AMTEX Enterprises, Inc.	$ 3,585.75

(CX-7).

(7) Employment Termination Records

In a notice of counseling from Stanley Stores, Inc., dated June 15, 1996, after three previous such counseling sessions, Claimant was terminated for poor performance in operating the cash register. (CX-22, p. 1). Claimant's cash drawer had an excessive shortage of $18.54 on June 14, 1996 and Claimant was instructed on May 29, 1996 that if he had one more shortage of ten dollars or more that he would be terminated. *Id*.

(8) Medical Records and Deposition of Dr. Kashinath Yadalam

On April 15, 1998, Dr. Yadalam, a psychiatrist at the Institute of Neuropsychiatry in Lake Charles, Louisiana, examined Claimant regarding bad mood swings. (CX-8, p. 4; CX-9, p. 16). Claimant reported suicidal thoughts, and Dr. Yadalam noted that Claimant was incarcerated for twenty months on a burglary conviction in 1993. (CX-9, p. 16). Dr. Yadalam interviewed Claimant in the presence of his mother, and noted that Claimant had taken lithium carbonate for at least five years to treat a bi-polar disorder. (CX-8, p. 8). Claimant also related that at the age of eighteen months he suffered a head injury which caused attention deficit disorder that he treated with psychostimulants of Dexedrine and Ritalin. *Id*. When Claimant overdosed on Dexedrine at the age of thirteen, his physician discontinued the use of that drug. *Id*. Claimant's depression was treated with Prozac and he had symptoms of thinking that people were watching him in stores. *Id*. Claimant further admitted to having thought broadcasting, meaning that he believed that other people could actually hear what he was thinking. *Id*. at 8-9. He also professed physical symptoms of ulcers, skin problems, and upper body

tremors. *Id*. at 9-10. Claimant was single, and gay. *Id*. at 10. His delusions were such that he thought that he was being persecuted and controlled. *Id*. As of the initial visit, Dr. Yadalam diagnosed schizoaffective disorder and prescribed medications of Zyprexa, Cogentin, Clonidine, lithium carbonate and Mellaril. *Id*. Dr. Yadalam based this diagnosis upon the history as reported by Claimant and his mother. Dr. Yadalam made no attempt to examine past treating records, order psycho neurological testing or independently verify Claimant's reported history of alleged hallucinations or delusions. Indeed, even as late as his deposition, Dr. Yadalam, other than reviewing a report by treating child psychiatrist, Dr. Margaret Williams and a brief report by Dr. Levy, did not take the time to review past treatment records, order objective testing or independently verify Claimant's or his mother's reported history. Rather, he accepted at face value what Claimant and his mother asserted as alleged fact. Further, when questioned about the specifics of the hallucinations or delusions, Dr. Yadalam was unable to give specifics. *Id.* a 24-41.

On the May 15, 1998 visit Dr. Yadalam noted that Claimant was depressed, and suffered from hallucinations and delusions. (CX-9, p. 15). However, by July 10, 1998, Claimant's thought process was normal, but he continued to suffer from a depressed and anxious mood. *Id*. at 14. Dr. Yadalam explained that there were different types of bi-polar disorder, and Claimant had the type labeled schizoaffective disorder, which shared many characteristics of schizophrenia. (CX-8, p. 12). Schizoaffective disorder was much worse than bi-polar disorder because it limited a patient's capacity to do a lot of things. *Id*. at 13. For example, constant hallucinations and delusions apparently associated with the disorder affected a person's concentration, making it very difficult to maintain employment because the person is distracted by voices and thinking that someone else is monitoring thoughts. *Id*. [1] Based only on Claimant's reported history, Dr. Yadalam had no doubt that Claimant had some kind of brain disorder that pre-existed his thirteenth birthday and did not believe Claimant could support himself. *Id*. at 15. Further, Dr. Yadalam opined that while Claimant may be able to obtain a job, he might not be able to maintain a job considering the side effects of his medication which could limit his concentration and cause sedation. *Id*. at 17. However, Claimant's progress notes do not show any side effects with generally normal attention, concentration and memory abilities. (CX-9, pp., 3, 4, 6 15).

Out of the hundreds of patients that Dr. Yadalam treats for schizoaffective disorders, only three or four could maintain any sort of employment. *Id*. at 18. Dr. Yadalam opined that Claimant could operate a motor vehicle, and may even be

able to live by himself. *Id*. at 35. If Claimant could work, Dr. Yadalam would encourage such activity because work was good for both his mind and body. *Id*. at 45.[2]

Based on an October 1988 discharge summary of child psychiatrist Dr. Williams, prepared when Claimant was fifteen years old, Dr. Yadalam opined that Claimant may have been able to perform certain tasks and could do so in the workforce at least from the ages of fifteen to eighteen. (CX-8, p. 49). Reviewing a July 9, 1980 report by Dr. Levy detailing brain dysfunction as early as 1977 in Claimant Everett, Dr. Yadalam related that Claimant likely suffered from his current problems for all of his life. *Id*. at 52. Based on Claimant's attempts and failures at work, and his apparent life-long mental problems, Dr. Yadalam opined that Claimant was probably incapable of self support ever since his second suicide attempt in 1988. *Id*. at 53. Claimant was in need of supervision in the event he had a lapse in his illness or used poor judgment, but he could generally take care of himself on medications. *Id*. at 55-56.

On September 19, 1999, Claimant complained that federal agencies were upsetting him because he was getting the "run around." (CX-9, p. 12). Once again, he was depressed and suffered from hallucinations and delusions. *Id*. at 12. On February 7, 2000, Claimant complained that he "was a basket case," and progress notes did not indicate any change in his condition throughout the years 2000-01. *Id*. at 5-11. On December 4, 2001, his house burned down. *Id*. at 5. Dr. Yadalam reported that the fact that Claimant self reported symptoms of hallucinations and delusions varied from visit to visit was very common in patients with a bi-polar disorder. (CX-8, p. 40).

Regarding Claimant's diagnosis of kleptomania, Dr. Yadalam stated that true kleptomania had nothing to do with a bi-polar disorder other than the fact that those with a bi-polar disorder can be very impulsive. (CX-8, p. 20). Dr. Yadalam also explained that Claimant's brother, Robert, also suffered a serious mental illness, and had even shot Claimant during a delusion. *Id*. at 40.

[2] While Dr. Yadalam described the limitations of a schizoaffective disorder associated with constant hallucinations or delusions, none of his progress notes on Claimant indicate clinical observations of such a condition. *Id.* at 28. Indeed on visits of July 10, 1998; October 7, 1998; August 6, 2001; December 4, 2001; March 26, 2002, July 2, 2002, there is no evidence of any thought disorder. Thus out of a total of 14 visits, (April 15, May 15, July 10, October 7, 1998; October 10, 1999; February 7, May 8, August 7, December 6, 2000; April 4, August 6, December 4, 2001; March 26, and July 24, 2002) 6 show no evidence even from Claimant or his mother of either hallucinations or delusions. (CX-9).

(9) Medical Record and Deposition of Dr. Lawrence Dilks

In a September 10, 1998 assessment by Dr. Lawrence S. Dilks, a psychologist for a Social Security disability determination, Dr. Dilks noted that Claimant Everett had a history of not being able to hold a job. (CX-10, p. 1). Dr. Dilks observed that Claimant was alert and coherent throughout the interview, had a blunt and shallow effect, and he found no evidence of a history of illusions or hallucinations. *Id*. at 2. Claimant was oriented to time, place, person, and situation. *Id*. He had an average intelligence quota and adequate concentration. *Id*. at 2-3. Dr. Dilks noted immature judgment, insight and reasoning, and a limited ability to abstract. *Id*. at 3. Dr. Dilks' diagnosis was bi-polar disorder type II, and personality disorder with border-lined schizoid and paranoid components. *Id*. Dr. Dilks' opinion was that Claimant's prognosis was guarded. *Id*. Although stabilized on medication, Claimant would benefit from individual counseling. *Id*. While Claimant could relate to others well, he likely had a low stress tolerance. *Id*. Claimant's daily activities were somewhat limited, but he was able to tend to his personal hygiene, watch television, make a sandwich, assist with yard work, and help his mother. *Id*. Dr. Dilks believed that with the appropriate counseling and therapy, Claimant could obtain gainful employment. *Id*.

In a subsequent deposition taken on March 7, 2005, Dr. Dilks confirmed his earlier assessment that Claimant was fluent in English and able to communicate freely. At the time of the assessment, Dr. Dilks had been provided a one page discharge summary showing Claimant to have a history of bi-polar disorder, ethanol abuse, kleptomania with a GAF of 55 indicating mild symptomatology. In Dr. Dilks' opinion, Claimant was not "disabled" i.e. or incapable of acquiring gainful employment. Rather, Claimant was an individual who could work.

Dr. Dilks testified that Claimant had a treatable bipolar disorder which was capable in a majority of cases of total remission with appropriate medication and therapy. On cross, Dr. Dilks noted that Claimant had borderline schizoid and paranoid traits, but did not meet the criteria for such a diagnosis and with no independent evidence of delusions or obsessions or paranoia. The schizoid and paranoid components are personality disorders that are maladaptive patterns of living, but by definition are not disabling but require avoidance of highly stressful situations. Dr. Dilks acknowledges that Dr. Yadalam was a competent psychiatrist, and that the treating profession with the most recent information gets "the most attention" in his profession.

(10) Medical Records of Dr. Shakeel S. K. Sandozi

On May 18, 1998, Dr. Sandozi performed surgery consisting of an esophagogastroduodenoscopy and anoscopy for internal hemorrhoids. (CX-18, p. 1). The surgery related to Claimant complaints of upper abdominal pain, a possible peptic ulcer disease, rectal bleeding and internal hemorrhoids. *Id*.

(11) Medical Records of St. Patrick Hospital and Dr. E.C. Smoot

On June 22, 1999, E.C. Smoot, a surgeon, operated on Claimant in regards to a gunshot wound to his left posterior neck, thorax, and back, and for a gunshot wound to his left medial thigh. Claimant also had a laceration to his lower lip. (CX-15, p. 2). Claimant was shot by his brother who used a twelve gauge shotgun at close range. *Id*. On July 9, 1999, Dr. Smoot noted that Claimant's skin graft over his wounds looked good, he was healing, and he removed the staples. (CX-16, p. 4). On November 1, 1999, Dr. Smoot released Claimant from his care and instructed him to return as needed. *Id*. at 12.

On July 23, 2001, Claimant returned to St. Patrick Hospital complaining of low back pain. (CX-15, p. 16). He rated his pain as moderate, acute and chronic. *Id*. at 16-17. A lumbar CT scan without contrast revealed a generalized bulge with minimal canal stenosis at L4-5. *Id*. at 18. Two radiological views of the lumbar spine revealed minimal lumbar dextroscoliosis. *Id*. at 19.

(12) Medical Records of Dr. King White

Dr. King reported on July 2, 2002 that Claimant had complained of three weeks of chest pain that was relieved with nitroglycerin. (CX-20, p. 1). An adenosine scan, performed on June 26, 2002 showed ischemia of the mild and distal anterior wall. *Id*. Dr. King admitted Claimant to the hospital on July 9, 2002, for cardiac cauterization. *Id*. A left heart cauterization revealed completely normal cardiac arteries, and Dr. King assured Claimant that his chest pain was not cardiac. *Id*. at 3-4.

(13) Vocational Rehabilitation of William J. Kramberg

On September 17, 2002, Mr. Kramberg, vocational expert, completed a vocational assessment and analysis of wage earning capacity on Claimant. (CX-24, p. 1). Claimant did not graduate from high school, attended a business college for a short time, but was asked not to come back and reported that he could not

keep up with his studies. *Id*. at 3. Brief vocational testing revealed that Claimant had a third grade equivalency in reading, a first grade equivalency in spelling, and a second grade equivalency in arithmetic. *Id*. at 4. Claimant reported that his burglary conviction was a result of his trying to live independently without supervision. *Id*. Considering Claimant's history of mental problems, including Dr. Yadalam's assessment and noting cardiovascular problems and a limited range of motion in his shoulder, Mr. Kramberg opined that it was not likely that Claimant would ever live independently and support himself as an adult. *Id*. Claimant may require institutional placement and/or supervised living should his mother no longer be able to case for him. *Id*.

IV. DISCUSSION

A. Contention of the Parties

Claimant contends that he has been totally dependent upon his mother and incapable of self support prior to and following his 18th birthday on July 31, 1991, due to a combination of physical and mental impairments and as such is entitled to continuing death benefits under the Act. To support this assertion Claimant relies primarily upon the reports and testimony of Dr. Yadalam and vocational expert, Mr. William J. Kramberg, in addition to his own testimony and that of his mother. Employer on the other hand relies upon the remaining medical records including those from Lake Charles Mental Health Clinic and Winn Correctional Center and the medical reports from treating psychiatrist, Dr. Alice P. Williams and Drs. George Middleton and Lawrence Dilks to show that Claimant was and has not been dependent upon his mother, Mary Hawkins.

Employer also argues that Claimant is collaterally estopped from contending that his disorder was diagnosed prior to September 10, 1993 or that the conditioned was disabling before May 23, 1995 citing *Drummond v Com'r of Social Security,* 126 f.3d 837 (6th Cir. 1997); *Galvin v. Heckler,* 81 F.2d 1195 (8th Cir.. 1987) and *U.S. v. Shanbaum,* 10 F.3d 305 (5th Cir.1994). Further prescription applies because Ms. Hawkins did not file the instant claim for benefits until March 10, 2000 rather than 1 year of Claimant's birthday, July 31, 1991, or within 1 year of disorder diagnosis on September 10, 1993, or within one year of her appointment as guardian on July 25, 1994. (CX-23). Indeed, Ms. Hawkins was well aware of her son's mental disorders and filed a claim under the Social Security Act on May 24,

1995 for child's insurance benefits alleging mental disorders as the basis for recovery. (CX-6, p. 6).

B. Credibility

It is well-settled that in arriving at a decision in this matter the finder of fact is entitled to determine the credibility of the witnesses, to weigh the evidence and draw his own inferences from it, and is not bound to accept the opinion or theory of any particular medical examiner. *Banks v. Chicago Grain Trimmers Association, Inc.*, 390 U.S. 459, 467 (1968); *Louisiana Insurance Guaranty Ass'n v. Bunol*, 211 F.3d 294, 297 (5th Cir. 2000); *Hall v. Consolidated Employment Systems, Inc.*, 139 F.3d 1025, 1032 (5th Cir. 1998); *Atlantic Marine, Inc., v. Bruce*, 551 F.2d 898, 900 (5th Cir. 1981); *Arnold v. Nabors Offshore Drilling, Inc.*, 35 BRBS 9, 14 (2001). Any credibility determination must be rational, in accordance with the law and supported by substantial evidence based on the record as a whole. *Banks*, 390 U.S. at 467, 88 S. Ct. at 1145-46; *Mijangos v. Avondale Shipyards, Inc.*, 948 F.2d 941, 945 (5th Cir. 1991); *Huff v. Mike Fink Restaurant, Benson's Inc.*, 33 BRBS 179, 183 (1999).

Employer contends that the record shows Claimant to be untrustworthy, manipulative, (CX-10, pp. 5, 19 51; CX-21, p. 142) motivated by secondary gain (CX-10, p .6), dishonest (CX-10, p.56), subject to hypochondriasis and malingering (CX-10, p. 84), relatively bright but a liar (CX-21, p. 117), and a petty but persistent thief (CX-10, pp. 29, 30, 48-50, 58, 59). Regarding Claimant's mother, Employer contends her testimony is influenced by a financial interest in the outcome of these proceedings, in that both mother and son pool their money with the mother administering funds as power of attorney. (Tr. 178, 209-210). Claimant's counsel argues that Claimant is delusional but nonetheless testified credibly about his poor work history and that he "embellishes or stretches the truth" occasionally merely to make himself look big or gain a advantage such as getting out of prison early.

After reviewing the entire record, I find Claimant's testimony to be in large part incredible and an attempt to manipulate or manufacture facts so as to portray himself incapable of self support, and thus, entitled to continued death benefits subsequent to his 18th birthday. In reaching that conclusion, I note that even Claimant's mother, Mary Hawkins, admitted on several occasions that Claimant had a past history of lying for personal gain. (Tr. 172, 193). Ms. Hawkins considered Claimant to be inherently untrustworthy allegedly because of his

mental illness, but took no step to correct his falsehoods when he was interviewed by social workers. (Tr. 218-19). Claimant's reputation for lying was also confirmed by his aunt, Edith Lejune. (Tr. 225). Claimant admitted lying to mental health officials at Winn Correctional facility where he was incarcerated for burglary concerning his use of drugs in order to get out of his cell. (Tr. 122-23). Winn Correctional records confirm Claimant's attempt to manipulate clinical psychologist to his advantage as did records from Lake Charles Mental Health Clinic. (CX-21, p 142, CX-1, p. 5, 6, 19).

Claimant asserted various physical impairments including heart pain with stress, low back pain preventing him from prolonged walking, lifting over 10 pounds, climbing stairs, sitting comfortably or riding in a car for over thirty minutes. There are no medical records to support such complaints. Indeed, heart testing procedures revealed normal results. (CX-20). While Claimant's medical records do indicate he was shot in neck and leg by his brother in June, 1999, there is no evidence to suggest continued limited movement of the left arm or inability to stay in the sun as Claimant asserted. (CX-15, 16, 17, and 19).

Concerning his mental limitations, Claimant asserted prior attempts at suicide in 1985 by overdosing on hyperactivity medication (Dexedrine) and in 1988, all of which allegedly required hospitalization. However, there is no hospitalization record in 1985 or any other year showing Claimant overdosing on Dexedrine or any other prescription drug. There is no reference to any drug abuse problem from the Children's Clinic of Southwest Louisiana where Claimant was prescribed and treated with Dexedrine from December, 1977, to July, 1988. (CX-11). Further, Claimant's hospitalization in 1988 was not for suicide attempts, but rather alleged thoughts of suicide. (CX-13). While Claimant alleged side effects of medication, i.e., sluggishness and weight gain from Lithium, hand shaking from Risperdal and Mellaril, and drooling from all medications, there is no medical documentation to back up these assertions even from one of Claimant's treating sources. Dr. Yadalam who claimed the medication affected Claimant's ability to concentrate, caused sedation, and affected the speed of cognitive functioning, Claimant certainly exhibited no lack of concentration or slow thinking processes, hand shaking, or drooling at the hearing. Indeed, his appearance and testimony were completely normal.

Concerning Claimant's alleged inability to work, while the record shows limited income from National Tea Company, H.J. Wilson, Goodwill Industries, Popeyes Famous Fried Chicken, Diamond Shamrock Refining, E-Z Mart Stores, Inc., PMB Enterprises, DeRidder Restaurant, Stanley Stores, Inc., Amtex

Enterprises, all but the last three employers involved employment in 1992 and 1993. Claimant was incarcerated from 1993 to 1995. Other than Claimant's testimony concerning his employment with each Employer there is no independent evidence to confirm or explain the duration of each job except for Stanley Stores which indicated termination apparently associated with cash shortages? (CX-22). There is also no documentation to support Claimant's assertion of while in prison of an inability to perform kitchen work. Progress notes from prison clinical psychologist, Dr. Van Buren show Claimant making steady progress making adjustment to prison life with better emotional integration and at times no need for any medication. (CX-21, pp. 129-140).

Ms. Hawkins testimony concerning Claimant's suicide attempts (drug overdose and shooting himself) was self serving and unsupported by medical documentation. She denied that Claimant worked for her on a part time basis although, the reports of Dr. Alice Williams showed otherwise. She also denied that Claimant spent a lot of time at the age of 15 taking care of himself at home although reports from Dr. Williams showed otherwise. Ms. Hawkins attempt to portray her son as unemployable was likewise unsupported by independent documentation and contrary to Dr. Williams' assessment of September 20, 1988 that Claimant could perform advanced housecleaning, household repair, maintenance, cooking, and sewing.

In like manner, I find unpersuasive the testimony Dr. Yadalam and Mr. Kramberg. As noted above, Dr. Yadalam without reviewing prior treatment records, ordering psychoneurological testing to obtain objective evidence of mental deficiencies, or attempting to clinically or independently verify facts as asserted by either Claimant or his mother, accepted as accurate the history reported by Ms. Hawkins and her son. None of Claimant's other credible treating sources diagnosed schizoaffective disorder nor did any of these sources classify Claimant as unemployable. Rather these sources including Drs. Williams, Dilks, Michael Stephens, found Claimant to have a treatable bipolar disorder with the capacity to work despite impairments.

C. Collateral Estoppel and Prescription

The doctrine of collateral estoppel or issue preclusion deals with the effect a prior judgment has in foreclosing successive litigation of an issue of fact or law litigated and resolved in a valid court determination essential to the prior judgment whether or not the issue arises in the same or different claim. *New Hampshire v.*

Maine, 121 S. Ct. 1808 (2001). As noted by Employer in its brief as page 8 the Fifth Circuit has addressed that doctrine on a number of occasions and in *Shanbaum, supra,* at 311 stated issue preclusion was appropriate when 4 conditions were met: (1) the issues under consideration in a subsequent action must be identical to the issues litigated in the prior action; (2) the issue must have been fully and vigorously litigated in the prior action; (3) the issue must have been necessary to support the judgment in the prior case; and (4) there must be no special circumstance that would render preclusion inappropriate or unfair. Further, if another court has already rendered a trustworthy determination of a given issue a party that has already litigated that issue should not be allowed to attach that determination in a second proceeding. The concept of collateral estoppel applies to administrative agency determinations made after trial type hearings involving finds of fact and conclusions of law as it does to other court litigation. *Drummond, supra,* at 841.

Claimant and his representative litigated the issues of disability (inability to engage in any substantial gainful activity) and manifestation of disability (onset of diagnosis of bipolar disorder on September 10, 1993 which met listing level severity on May 23, 1995) before ALJ Charles R. Lindsay in a claim for child's insurance benefits under the Social Security Act filed by Claimant on May 24, 1995. Although the Social Security Act and Longshore Act define disability in different terms, disability under the Social Security Act or the inability to engage in any substantial gainful activity is essentially the same as the inability of an individual to engage in self support as specified in Section 2 (14) of the Longshore Act. Thus, the issues of disability and onset of disability are identical between the instant proceeding and the prior proceeding before Judge Lindsay.

It is apparent that the issues of disability and onset of disability were fully and vigorously litigated in the prior proceeding, and necessary to support the judgment in the prior proceeding. Moreover, I find no special circumstances that would render preclusion inappropriate or unfair especially since Claimant was represented in those proceedings and was successful in achieving the desired social security benefits.

Regarding the issue of preclusion, Claimant had one year from the date of diagnosis, September 10, 1993 or from May 24, 1995, when Claimant's mother filed the claim for child's insurance benefits due to mental disorders in which to file the current claim. Claimant clearly did not meet either deadline having filed the instant claim on March 10, 2000.

D. Dependent Child Benefits

In order for Claimant to be successful in the present proceeding he must show his dependency upon Gilbert Hawkins at the time of the latter's death and the incapacity as of his 18th birthday (July 31, 1991), of self support by reason of a mental or physical impairment. The first element of dependency was established by the parties stipulation and is thus not in dispute. What is fiercely contested is Claimant's alleged incapacity, as of his eighteenth birthday, to be self supporting due to either a mental or physical impairment.

Regarding the issue of incapacity I do not credit either Claimant or his mother's self serving statements as noted above. To the extent that either Mr. Kramberg or Dr. Yadalam relied upon either Claimant or his mother in providing "details" of Claimant's mental disorder without any verification of pre-existing records or objective testing I do not credit their testimony. Rather, I rely upon the records of the Lake Charles Mental Health Clinic, Winn Correctional Center, and medical reports from treating psychiatrist, Dr. Alice Williams and Drs. George Middleton and Lawrence Dilks to show that Claimant is capable of self support, and thus, not entitled to benefits.

However, aside from the substantive issue of self support, I find merit to Employer's argument of collateral estoppel and prescription and find that Claimant and his representative failed to file the claim within a year of learning of the bipolar diagnosis and its alleged disabling effects, and further, that Claimant is collaterally estoppel from alleging either an earlier date than September 10, 1993 for onset of a bipolar disorder or May 25, 1995 for meeting disability listing level.

In any event, whether from a procedural or substantive basis, I find the instant claim has no merit and accordingly dismiss it.

V. ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law and upon the entire record, I enter the following Order:

The instant claim has no procedural or substantive merit and is dismissed.

A

CLEMENT J. KENNINGTON
Administrative Law Judge